HUMANA
Guidance when you need it most

Health Reimbursement Account and Flexible Spending Account Claim Form

Part I: Employee Information (Please Print)

Employee Name (Last/First/M.I.)	Date of Birth	Social Security Number
Employee e-mail Address – *Completion of e-mail address will auto enroll you to receive account e-mail correspondence.*		Daytime Telephone Number

Part II: Reimbursement Request

Types of Service Combine all same Type of Service Expenses	**Dates of Service**		**Explanation of Benefits (E.O.B.) Included (Y/N)**		**Total Requested Amount**
	Beginning Date	Ending Date	*Explanation of Benefits (EOB)	Itemized receipt	
Medical					
Vision					
Prescription					
Over-the-Counter Medication (OTC)					
Dental					
Durable Medical Equipment					
Other					
				Total Requested Amount	

Part III: Dependent Care Affidavit and Reimbursement Request

	Dependent's Full Name	**Date of Birth**	**Dates of Service**		**Total Requested Amount**	**Adult**	**DayCamp**	**Daycare**
			Beginning Date	Ending Date				
1								
2								
				Total Requested Amount:				

Provider Tax ID: (optional)		**Provider Name:**

I provided Adult/Child Care Services to the above individuals in accordance with the amounts and dates that are requested:

Provider Signature: _____ **Date:** _____

TO EXPEDITE CLAIM PAYMENT, PLEASE FILL OUT COMPLETE CLAIM FORM.

Part IV: Employee Certification for Reimbursement

I hereby certify that:

- The above information is correct;
- I have not received reimbursement previously from my HRA/FSA or any other plan, including through the use of my Humana*Access*℠ Visa® Debit Card, and these expenses are not eligible for reimbursement under any other plan; and I understand that:
  - Dependent care expenses reimbursed through this account cannot be used as a dependent care credit on my personal tax return;
  - Reimbursement is not a guarantee that this payment is tax free; and
  - Health care expenses reimbursed through this account cannot be used as a deduction on my personal income tax return.

I hereby authorize release of payment through my Health Reimbursement Account or Flexible Spending Account. I hereby authorize Humana Inc. or its representatives to obtain necessary information from all physicians, hospitals, medical service providers, pharmacists, employers, and all other agencies or organizations (this includes other insurers) to consider the claim for reimbursement under my Health Reimbursement Account or Flexible Spending Account.

Employee Signature: _____ **Date:** _____

kyhealthplan.humana.com – Reimbursement Request Form Instructions

Mail or fax your claim form to:

Fax Submission – To expedite your claim payment, fax the completed and signed reimbursement claim form, along with all documentation to fax number 1-800-905-1851. **Note: fax one claim form and its documentation per transmission.**

Mail Submission – Please mail the completed and signed reimbursement claim form, along with all documentation to Humana Spending Account Administration, P.O. Box 3967, Louisville, KY 40201-3967.

Employee Instructions

Please read these instructions before completing the information requested on the Health Reimbursement Account and Flexible Spending Account claim form.

1. Complete all areas of Part I "Employee Information." Where applicable, complete Part II "Reimbursement Request."
2. All health care expenses should first be filed under your employer's health care plan or any other coverage you may have before you request reimbursement from your Health Reimbursement Account or Flexible Spending Account.
3. This form is to be used only to request reimbursement for:

Health Care Expenses

- Allowable expenses covered, but not fully reimbursed by any benefit plans. Attach a copy of the plan's Explanation of Benefits statement (EOB) as documentation.
- Allowable expenses **not** covered by any benefit plans. Attach bills or receipts that indicate the name and address of the provider of service. Please note on the form if the expense is not covered by a health or dental plan.

Supporting Documentation – Health Care Expenses

In addition to the completion of the reverse side of this form, the documentation described under either A or B below must be attached to this form.

A. **Explanation of Benefits statement (EOB)**: This is the statement you receive each time you, or a health care provider, submit medical, dental or vision claims for payment to your health, dental or vision care plan. The EOB will show the amount of expenses paid by the plan and the amount you must pay. If you are covered under a HMO/DMO indicate "Copayment" on Part II under "Type(s) of Service."

B. **All Other Expenses: For expenses not covered at all by your (or your dependent's) medical, dental or vision plans, reimbursement requests will not be processed without acceptable evidence of your expenses.** A cancelled check is not considered acceptable evidence. Acceptable evidence includes receipts, which contain the following information:
   - Type of service or product provided
   - Date expense was incurred
   - Name of employee or dependent for whom the service/product was provided
   - Person or organization providing the service/product
   - Amount of expense

Dependent Care Expenses

In general, the following rules apply to dependent care expenses:

- Dependent care expenses qualify if they are for the care of children or other dependents that are physically or mentally incapable of caring for themselves. These expenses must be incurred so that you and your spouse, if married, can work or your spouse can attend school full time.
- Children must be under age 13.
- Services provided by a childcare or elder care center must comply with all state and local laws to be an eligible reimbursement expense.

The annual amount of dependent care claims cannot exceed:

- Your annual deposit amount up to $5,000 ($2,500 if you and your spouse are filing separate returns), or
- Your annual salary or your spouse's annual salary, if less than $5,000.

Supporting Documentation – Dependent Care Expenses

- For allowable Dependent (Day) Care expenses, attach a copy of the receipt with exact dates of service (e.g. 7/5/06-7/9/06), or have the provider complete Part III, "Dependent Care Affidavit and Reimbursement Request" on the reverse side.
- For allowable Dependent Care expenses, attach a copy of the bill or have the provider complete and sign Part III, "Dependent Care Affidavit and Reimbursement Request", on the reverse side.

4. Read the Employee Certification for Reimbursement statement, then sign and date the form where indicated.

Questions? Call Humana Customer Service Center at 1-800-604-6228.